STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS3303ASC	A. BUILDING _____ B. WING _____	03/13/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INSTITUTE OF ORTHOPAEDIC SURGERY LLC	**2800 E DESERT INN ROAD LAS VEGAS, NV 89121**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 00	INITIAL COMMENTS This Statement of Deficiencies was generated as the result of a focused state licensure survey and a complaint investigation conducted at your facility on March 13, 2008. The following complaint was investigated. CPT #17581 Unsubstantiated The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state or local laws. The state licensure survey was conducted in accordance with Chapter 449, Surgical Centers for Ambulatory Patients, adopted by the State Board of Health effective 9-27-99. There were no regulatory deficiencies were identified.	A 00		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE